FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041871

Facility Name: PROVENA ST JOSEPH CENTER

Address: 659 E. JEFFERSON (Number) FREEPORT (City) 61032 (Zip Code)

County: STEPHENSON

Telephone Number: (815) 232-6181 **Fax #** (815) 232-6143

IDPA ID Number: 371127787011

Date of Initial License for Current Owners: 07/01/96

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) STEVEN N. LAVENDA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		1	2,656	2,657	8
9	SNF/PED					9
10	ICF	17,360	21,505		38,865	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,360	21,506	2,656	41,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.80%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2656

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,150	33,548	10,265	301,963		301,963		301,963			1
2	Food Purchase		229,834		229,834		229,834	(113,996)	115,838			2
3	Housekeeping	99,528	10,140		109,668		109,668	1,830	111,498			3
4	Laundry	105,508	26,745		132,253		132,253		132,253			4
5	Heat and Other Utilities			156,021	156,021		156,021	935	156,956			5
6	Maintenance	81,869	10,651	54,309	146,829		146,829	(5,070)	141,759			6
7	Other (specify):*											7
8	TOTAL General Services	545,055	310,918	220,595	1,076,568		1,076,568	(116,301)	960,267			8
	B. Health Care and Programs											
9	Medical Director			4,458	4,458		4,458		4,458			9
10	Nursing and Medical Records	1,562,581	88,074	92,720	1,743,375		1,743,375	12,279	1,755,654			10
10a	Therapy	48,203			48,203		48,203		48,203			10a
11	Activities	54,264	3,322	2,465	60,051		60,051		60,051			11
12	Social Services	80,218	590	762	81,570		81,570	5,599	87,169			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,732	4,732			15
16	TOTAL Health Care and Programs	1,745,266	91,986	100,405	1,937,657		1,937,657	22,610	1,960,267			16
	C. General Administration											
17	Administrative	77,700		465,600	543,300		543,300	(462,419)	80,881			17
18	Directors Fees											18
19	Professional Services			55,201	55,201		55,201	20,916	76,117			19
20	Dues, Fees, Subscriptions & Promotions			7,943	7,943		7,943	1,329	9,272			20
21	Clerical & General Office Expenses	87,443	10,115	105,659	203,217		203,217	18,353	221,570			21
22	Employee Benefits & Payroll Taxes			502,709	502,709		502,709	(6,187)	496,522			22
23	Inservice Training & Education							17,940	17,940			23
24	Travel and Seminar			12,051	12,051		12,051	(5,910)	6,141			24
25	Other Admin. Staff Transportation			1,984	1,984		1,984	4,225	6,209			25
26	Insurance-Prop.Liab.Malpractice			20,283	20,283		20,283	1,232	21,515			26
27	Other (specify):*							39,069	39,069			27
28	TOTAL General Administration	165,143	10,115	1,171,430	1,346,688		1,346,688	(371,452)	975,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,455,464	413,019	1,492,430	4,360,913		4,360,913	(465,143)	3,895,770			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA ST JOSEPH CENTER #0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			163,600	163,600		163,600	(93,293)	70,307			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							221,461	221,461			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							14,163	14,163			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			494	494		494		494			36
37	**TOTAL Ownership**			164,094	164,094		164,094	142,331	306,425			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		419,131	136,419	555,550		555,550		555,550			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*	32,700	1,479	13,258	47,437		47,437	(47,437)				43
44	**TOTAL Special Cost Centers**	32,700	420,610	215,377	668,687		668,687	(47,437)	621,250			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,488,164	833,629	1,871,901	5,193,694		5,193,694	(370,249)	4,823,445			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(113,996)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	156	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,902)	21		24
25	Fund Raising, Advertising and Promotional	(615)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(177,918)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (373,275)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,026		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,026		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (370,249)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PROVENA ST JOSEPH CENTER

ID# 0041871

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	OTHER INCOME	(5,213)	21	2
3	DEVELOPMENT SALARIES	(32,700)	43	3
4	DEVELOPMENT SUPPLIES	(1,479)	43	4
5	DEVELOPMENT OTHER	(13,258)	43	5
6	OUTREACH FUNDRAISER	(4)	20	6
7	EXECUTIVE BENEFITS	(6,187)	22	7
8	CAPITALIZED ASSETS	(3,184)	06	8
9	MISC PROFESSIONAL FEES	(488)	19	9
10	NON-CARE ASSET DEPRECIATION	(93,449)	30	10
11	NON-CARE ASSET MAINTENANCE	(3,365)	06	11
12	RENTAL INCOME - NON CARE ASSETS	(6,540)	32	12
13	NON-ALLOWABLE SEMINAR	(12,051)	24	13
14				14
15				15
16				16
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(113,996)											(113,996)	2
3	Housekeeping			1,830									1,830	3
4	Laundry													4
5	Heat and Other Utilities			935									935	5
6	Maintenance	(6,549)		1,479									(5,070)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(120,545)		4,244									(116,301)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			12,279									12,279	10
10a	Therapy													10a
11	Activities													11
12	Social Services			5,599									5,599	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			4,732									4,732	15
16	**TOTAL Health Care and Programs**			22,610									22,610	16
	C. General Administration													
17	Administrative			(462,419)									(462,419)	17
18	Directors Fees													18
19	Professional Services	(488)		21,404									20,916	19
20	Fees, Subscriptions & Promotions	(619)		1,948									1,329	20
21	Clerical & General Office Expenses	(86,115)		104,468									18,353	21
22	Employee Benefits & Payroll Taxes	(6,187)											(6,187)	22
23	Inservice Training & Education			17,940									17,940	23
24	Travel and Seminar	(12,051)		6,141									(5,910)	24
25	Other Admin. Staff Transportation			4,225									4,225	25
26	Insurance-Prop.Liab.Malpractice			1,232									1,232	26
27	Other (specify):*			39,069									39,069	27
28	**TOTAL General Administration**	(105,460)		(265,992)									(371,452)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(226,005)		(239,138)									(465,143)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(93,293)											(93,293)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,540)		228,001									221,461	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			14,163									14,163	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(99,833)		242,164									142,331	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(47,437)											(47,437)	43
44	**TOTAL Special Cost Centers**	(47,437)											(47,437)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(373,275)		3,026									(370,249)	45

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PROVENA SENIOR SERVICES	100%	SEE ATTACHED		SEE ATTACHED		
PROVENA HEALTH	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PROVENA SENIOR SERVICES	100.00%	$ 1,830	$ 1,830	15
16	V	5	UTILITIES		PROVENA SENIOR SERVICES	100.00%	935	935	16
17	V	6	REPAIRS AND MAINT.		PROVENA SENIOR SERVICES	100.00%	1,479	1,479	17
18	V	10	NURSING		PROVENA SENIOR SERVICES	100.00%	12,279	12,279	18
19	V	12	SOCIAL SERVICES		PROVENA SENIOR SERVICES	100.00%	5,599	5,599	19
20	V	15	EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	4,732	4,732	20
21	V	17	ADMINISTRATIVE	525,000	PROVENA SENIOR SERVICES	100.00%	62,581	(462,419)	21
22	V	19	PROFESSIONAL FEES		PROVENA SENIOR SERVICES	100.00%	21,404	21,404	22
23	V	20	DUES,SUBSCRIPTIONS		PROVENA SENIOR SERVICES	100.00%	1,948	1,948	23
24	V	21	CLERICAL		PROVENA SENIOR SERVICES	100.00%	104,468	104,468	24
25	V	23	INSERVICE TRAINING		PROVENA SENIOR SERVICES	100.00%	17,940	17,940	25
26	V	24	SEMINARS		PROVENA SENIOR SERVICES	100.00%	6,141	6,141	26
27	V	25	ADMIN. STAFF TRAVEL		PROVENA SENIOR SERVICES	100.00%	4,225	4,225	27
28	V	26	INSURANCE		PROVENA SENIOR SERVICES	100.00%	1,232	1,232	28
29	V	27	EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	39,069	39,069	29
30	V	32	INTEREST-DIRECT ALLOCATION		PROVENA SENIOR SERVICES	100.00%	228,001	228,001	30
31	V	34	RENT		PROVENA SENIOR SERVICES	100.00%	14,163	14,163	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 525,000			$ 528,026	$ * 3,026	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	PHARMACY-STOCK ITEMS	$ 5,489	PROVENA SENIOR SERVICES PHARMACY	100.00%	$ 5,489	$	15
16	V	39	PHARMACY	411,637	PROVENA SENIOR SERVICES PHARMACY	100.00%	411,637		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 417,126			$ 417,126	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	COMPUTER	$ 50,004	PROVENA HEALTH	100.00%	$ 50,004	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,004			$ 50,004	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA SENIOR SERVICES
Street Address: 200 E. COURT STREET, SUITE 200
City / State / Zip Code: KANKAKEE, IL. 60901
Phone Number: (815) 928-6851
Fax Number: (847) 928-6160

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MGT FEE INCOME	5,221,293	17	$ 18,200	$	525,000	$ 1,830	1
2	5	UTILITIES	MGT FEE INCOME	5,221,293	17	9,294		525,000	935	2
3	6	REPAIRS AND MAINT.	MGT FEE INCOME	5,221,293	17	14,705		525,000	1,479	3
4	10	NURSING	MGT FEE INCOME	5,221,293	17	122,116	122,116	525,000	12,279	4
5	12	SOCIAL SERVICES	MGT FEE INCOME	5,221,293	17	55,680	55,680	525,000	5,599	5
6	15	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	47,063		525,000	4,732	6
7	17	ADMINISTRATIVE	MGT FEE INCOME	5,221,293	17	622,384	622,384	525,000	62,581	7
8	19	PROFESSIONAL FEES	MGT FEE INCOME	5,221,293	17	212,867		525,000	21,404	8
9	20	DUES,SUBSCRIPTIONS	MGT FEE INCOME	5,221,293	17	19,371		525,000	1,948	9
10	21	CLERICAL	MGT FEE INCOME	5,221,293	17	1,038,965	958,360	525,000	104,468	10
11	23	INSERVICE TRAINING	MGT FEE INCOME	5,221,293	17	178,422		525,000	17,940	11
12	24	SEMINARS	MGT FEE INCOME	5,221,293	17	61,070		525,000	6,141	12
13	25	ADMIN. STAFF TRAVEL	MGT FEE INCOME	5,221,293	17	42,016		525,000	4,225	13
14	26	INSURANCE	MGT FEE INCOME	5,221,293	17	12,250		525,000	1,232	14
15	27	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	388,552		525,000	39,069	15
16	32	INTEREST-DIRECT ALLOCAT	DIRECT ALLOCATION			2,258,265			228,001	16
17	34	RENT	MGT FEE INCOME	5,221,293	17	140,857		525,000	14,163	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,242,077	$ 1,758,540		$ 528,026	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA SENIOR SERVICES PHARMACY
Street Address: 1475 HARVARD DRIVE
City / State / Zip Code: KANKAKEE, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	PHARMACY-STOCK ITEMS	DIRECT ALLOCATION						5,489	1
2	39	PHARMACY	DIRECT ALLOCATION						411,637	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 417,126	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PROVENA HEALTH
Street Address 9223 WEST ST. FRANCIS ROAD
City / State / Zip Code FRANKFURT, IL 60423
Phone Number (815)469-4888
Fax Number (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	COMPUTER	DIRECT ALLOCATION						50,004	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 50,004	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Alloc-Provena Senior Services	X									228,001	11
12	RENTAL INCOME										(6,540)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 221,461	14
15	TOTALS (line 9+line14)						$	$			$ 221,461	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA ST JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,080 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ST. VINCENT ADULT DAY CARE - 7285 SQ FT
SUPPORTIVE LIVING APARTMENTS- 7285 SQ FT
COMMUNITY LIVING - 10365 SQ FT
RENTAL HOMES - 4034 SQ FT
SUPPORTIVE LIVING HOUSE - 4460 SQ FT
OLD ST. JOSEPH HOME (NO LONGER USED) - 33000 SQ FT
STORAGE - 19700 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1996	$ 561,960	1
2					2
3	TOTALS			$ 561,960	3

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996	1994	$ 1,003,500	$ 25,089	35	$ 25,088	$ (1)	$ 137,981	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	1,409		20	141	141	634	9
10	Various			1997	14,108		20	2,243	2,243	8,929	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			8,136			(8,136)		69
70	TOTAL (lines 4 thru 69)		$ 1,019,017	$ 33,225		$ 27,472	$ (5,754)	$ 147,544	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,019,017	$ 33,225		$ 27,472	$ (5,754)	$ 147,544	1
2	HANDICAPPED ACCESSIBLE BATHROOMS (5)	1998	3,718		20	372	372	1,301	2
3	CARPETING FOR ADC	1998	3,100		20	517	517	3,100	3
4	NONCARE PORTION OF LIMP	1998	(4,081)		20	(532)	(532)	(2,634)	4
5	CLF AIR CONDITIONING	1999	44,536		20	2,227	2,227	5,567	5
6	AIR CONDITIONING UNIT	1999	20,312		20	2,031	2,031	5,078	6
7	CARPET, PAD, & LINO	1999	2,077		20	415	415	1,039	7
8	RESTROOM REMODELING	1999	13,850		20	1,385	1,385	3,463	8
9	DISPENSERS (TOWELS & TISSUE)	1999	151		20	30	30	75	9
10	NONCARE PORTION OF LIMP	1999	(48,442)		20	(3,149)	(3,149)	(8,615)	10
11	RGB ARCHITECTURAL SERVICES	2000	709		20	142	142	213	11
12	SHOWER (3 PC)	2000	567		20	81	81	122	12
13	ROOF (O'NEIL HALL ARCHIVE ROOM)	2000	1,290		20	258	258	387	13
14	FIX STEAM LEAK	2000	1,729		20	346	346	519	14
15	FIX CONDENSATE LEAK/MAIN BOILER ROOM	2000	538		20	108	108	161	15
16	STJ COMMON AREA ASSESSMENT	2000	3,098		20	620	620	929	16
17	HVAC UNIT	2000	1,917		20	383	383	575	17
18	RGB MAJOR BUILDING CONSULTING	2000	5,712		20	571	571	857	18
19	FISCHER EXCAVATING	2000	1,605		20	321	321	481	19
20	SEALCOAT ASPHALT	2000	4,729		20	946	946	1,419	20
21	NONCARE PORTION OF LIMP	2000	(13,106)		20	(2,260)	(2,260)	(3,390)	21
22	WATER SOFTENER REPLACEMENT	2001	5,642		20	282	282	282	22
23	ALARM RELAYS, SWITCHES, ETC	2001	2,372		20	237	237	237	23
24	BATHROOM/KITCHEN REMODELING	2001	5,246		20	131	131	131	24
25	NEW AIR COMPRESSOR	2001	4,042		20	202	202	202	25
26	STEAM LINE REPAIRED	2001	1,793		20	179	179	179	26
27	RGB ARCHITECTURAL SERVICES	2001	2,165		20	217	217	217	27
28	RGB ARCHITECTURAL SERVICES (4/27/01)	2001	45		20	8	8	8	28
29	NEW WATER MAIN FOR ADC, OLD LINE WAS	2001	6,339		20	634	634	634	29
30	REPLACE WATER SERVICE - SLA HOUSE	2001	932		20	93	93	93	30
31	BLACKTOP WORK	2001	2,650		20	442	442	442	31
32	PATCH HOLE	2001	1,542		20	154	154	154	32
33	CONCRETE PATIO	2001	550		20	28	28	28	33
34	TOTAL (lines 1 thru 33)		$ 1,096,344	$ 33,225		$ 34,889	$ 1,664	$ 160,796	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,096,344	$ 33,225		$ 34,889	$ 1,664	$ 160,796	1
2	HOT WATER HEATER REPAIRS	2001	1,614		20	81	81	81	2
3	PIPE REPAIRS	2001	1,020		20	51	51	51	3
4	NONCARE PORTION OF LIMP	2001	(21,521)		20	(1,639)	(1,639)	(1,639)	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,077,457	$ 33,225		$ 33,382	$ 157	$ 159,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 211,279	$ 25,854	$ 25,854	$ (0)	10	$ 117,735	71
72	Current Year Purchases	13,137	1,221	1,221	0	10	1,221	72
73	Fully Depreciated Assets	350				10	350	73
74								74
75	TOTALS	$ 224,766	$ 27,075	$ 27,075	$ (0)		$ 119,306	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 MERCURY SABLE	2001	$ 23,123	$ 3,854	$ 3,854	$ (0)	5	$ 3,854	76
77	FACILITY	1997 DODGE 2500	1997	24,090	4,818	4,818	(0)	5	21,681	77
78	FACILITY	98 FALCON, 87 CHEVY BUS	1998	2,502	372	372		5	1,504	78
79	FACILITY	1999 DODGE MAXIWAGON	1999	6,450	806	806		5	2,016	79
80	TOTALS			$ 56,165	$ 9,850	$ 9,850	$ (0)		$ 29,054	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,920,348	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,150	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,306	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 156	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 307,650	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NON-CARE AUTO - 1998	$ 26,856	$ 3,536	$ 10,558	86
87	NON-CARE PORTION OF LAND - 2001	838,040			87
88	NON - CARE BUILDING - 1994	1,496,500	37,410	205,757	88
89	NON-CARE LEASEHOLD - VAR	110,290	12,132	30,538	89
90	NON-CARE PORTION OF EQUIP - 200	335,144	40,371	177,500	90
91	TOTALS	$ 2,806,830	$ 93,449	$ 424,353	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	ALLOCATED PROVENA SENIOR SERVICES				14,163			6
7	TOTAL				$ 14,163 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 55,498	$		$ 55,498	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,892			2,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			78,029			78,029	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				417,126		417,126	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						2,005		2,005	13
14	TOTAL			$		$ 136,419	$ 419,131		$ 555,550	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,989,309	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,604,498		3
4	Supply Inventory (priced at)	447,185		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	424,582		7
8	Accounts Receivable (owners or related parties)	130,474		8
9	Other(specify): See supplemental schedule	457,513		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,053,561	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,516,166		12
13	Land	7,818,584		13
14	Buildings, at Historical Cost	69,593,771		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,395,931		16
17	Accumulated Depreciation (book methods)	(33,036,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	72,837		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	5,331,935		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,692,696	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 86,746,257	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,713,457	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	494,877		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,663,513		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,659		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	636,912		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,520,418	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	44,263,363		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 44,263,363	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 49,783,781	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 36,962,476	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 86,746,257	$	48

*(See instructions.)

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 34,695,680	1	
2	Restatements (describe):		2	
3	**Adjustment to Reconcile Consolidated Opening Equity**	2,143,661	3	
4	**and Consolidated Net Income to Nursing Facility**		4	
5	**Amounts**		5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 36,839,341	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	123,135	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 123,135	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 36,962,476	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,320,612	1
2	Discounts and Allowances for all Levels	(120,299)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,200,313	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	257,012	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 257,012	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,024	13
14	Non-Patient Meals	113,996	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	517,543	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 633,563	23
	D. Non-Operating Revenue		
24	Contributions	214,188	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 214,188	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	11,753	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,753	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,316,829	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,076,568	31
32	Health Care	1,937,657	32
33	General Administration	1,346,688	33
	B. Capital Expense		
34	Ownership	164,094	34
	C. Ancillary Expense		
35	Special Cost Centers	602,987	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,193,694	40
41	**Income before Income Taxes (line 30 minus line 40)****	123,135	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 123,135	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,080	$ 54,773	$ 26.33	1
2	Assistant Director of Nursing	1,888	2,080	47,722	22.94	2
3	Registered Nurses	17,226	18,683	347,389	18.59	3
4	Licensed Practical Nurses	18,016	19,619	292,245	14.90	4
5	Nurse Aides & Orderlies	78,736	84,889	781,762	9.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,393	4,902	48,203	9.83	8
9	Activity Director	1,960	2,126	24,285	11.42	9
10	Activity Assistants	3,583	3,807	29,979	7.87	10
11	Social Service Workers	5,924	7,801	80,218	10.28	11
12	Dietician					12
13	Food Service Supervisor	4,039	4,399	57,167	13.00	13
14	Head Cook	8,997	9,693	82,419	8.50	14
15	Cook Helpers/Assistants	16,865	17,984	118,564	6.59	15
16	Dishwashers					16
17	Maintenance Workers	7,168	7,830	81,869	10.46	17
18	Housekeepers	11,126	12,545	99,528	7.93	18
19	Laundry	11,567	13,193	105,508	8.00	19
20	Administrator	1,616	2,352	77,700	33.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,367	7,866	87,443	11.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,023	4,362	38,690	8.87	31
32	Other Health Care(specify)					32
33	Other(specify)	2,046	2,418	32,700	13.52	33
34	TOTAL (lines 1 - 33)	208,412	228,629	$ 2,488,164 *	$ 10.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 10,265	01-03	35
36	Medical Director	monthly	4,458	09-03	36
37	Medical Records Consultant	21	761	10-03	37
38	Nurse Consultant	monthly	2,490	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	76	2,465	11-03	44
45	Social Service Consultant	22	762	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	119	$ 21,201		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	928	$ 41,766	10-03	50
51	Licensed Practical Nurses	1,916	44,066	10-03	51
52	Nurse Aides	182	3,637	10-03	52
53	TOTAL (lines 50 - 52)	3,026	$ 89,469		53

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
THERESA PARSEK	ADMINISTRATOR	0.00%	$ 77,700
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,700

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - PROVENA SENIOR SERVICES	$ 214,900
MANAGEMENT FEES - INTEREST	250,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 465,600

C. Professional Services

Vendor/Payee	Type	Amount
BARMANN, KRAMER & BOHLEN	LEGAL	$ 459
PROVENA HEALTH	COMPUTER SERVICES	50,004
WELLSPRING	CQI CONSULTANT	4,000
MISC PROFESSIONAL FEES	ADJUSTED OUT PAGE 5	488
HEALTHCARE FURNISHINGS	FURNISHING CONSULTANT	250
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 55,201

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,772
Unemployment Compensation Insurance	8,476
FICA Taxes	180,046
Employee Health Insurance	188,840
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION EXPENSE	27,166
DENTAL	30,730
VISION	3,695
SPECIAL EVENT	1,198
OTHER EMPLOYEE BENEFITS	4,598
TOTAL (agree to Schedule V, line 22, col.8)	$ 496,521

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,071
Health Care Worker Background Check	427
(Indicate # of checks performed 61)	
DUES AND SUBSCRIPTIONS	5,826
PROMOTIONAL ADVERTISING	615
ALLOC-PROVENA SENIOR SERVICES	1,948
Less: Public Relations Expense	
Non-allowable advertising	(615)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,272

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
ALLOC-PROVENA SENIOR SERVICES	6,141
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,141

**See instructions.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN $5204

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,700
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT AVAILABLE

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees